

001210782625560

FIG. 1

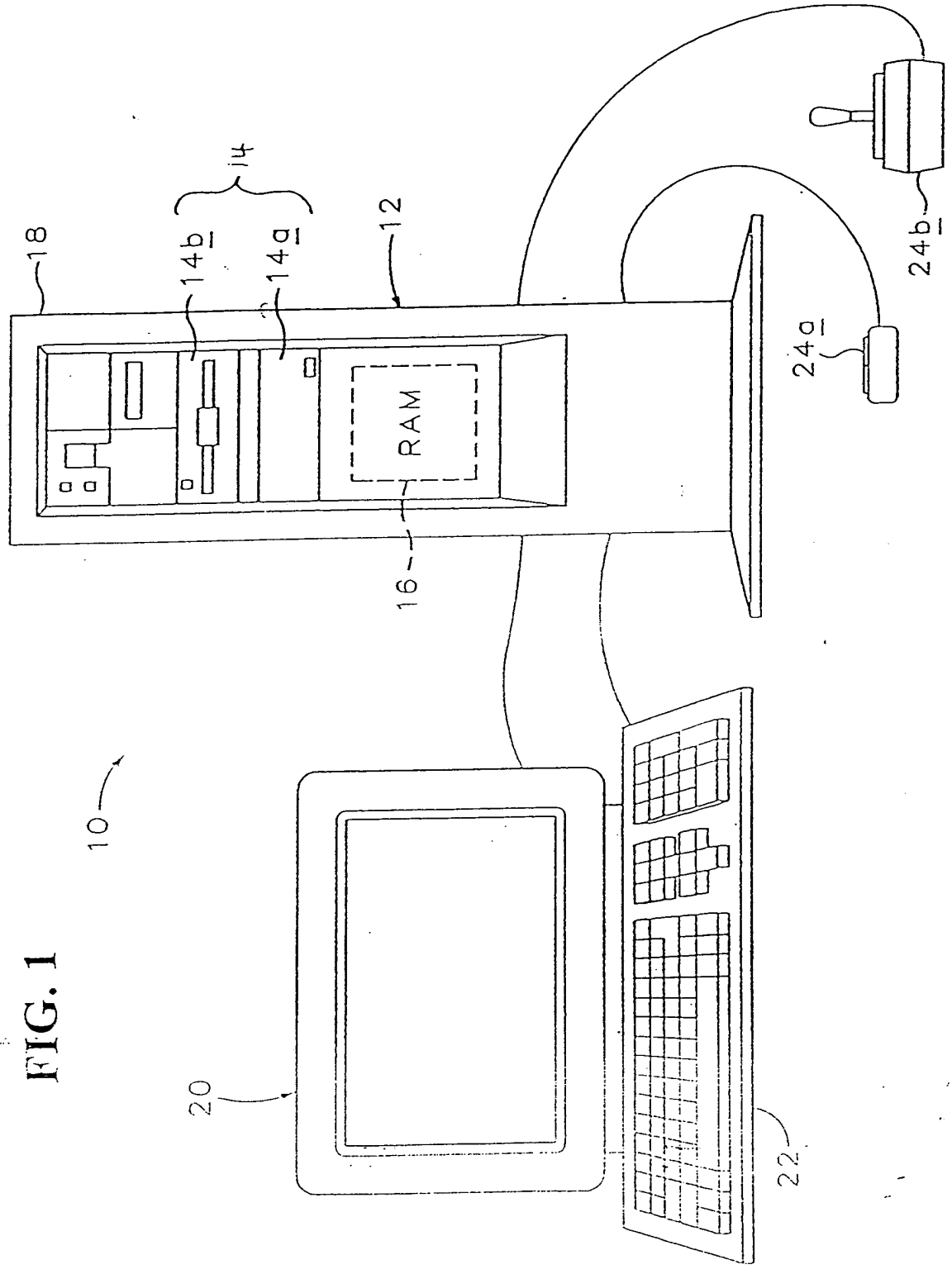


Fig. 2

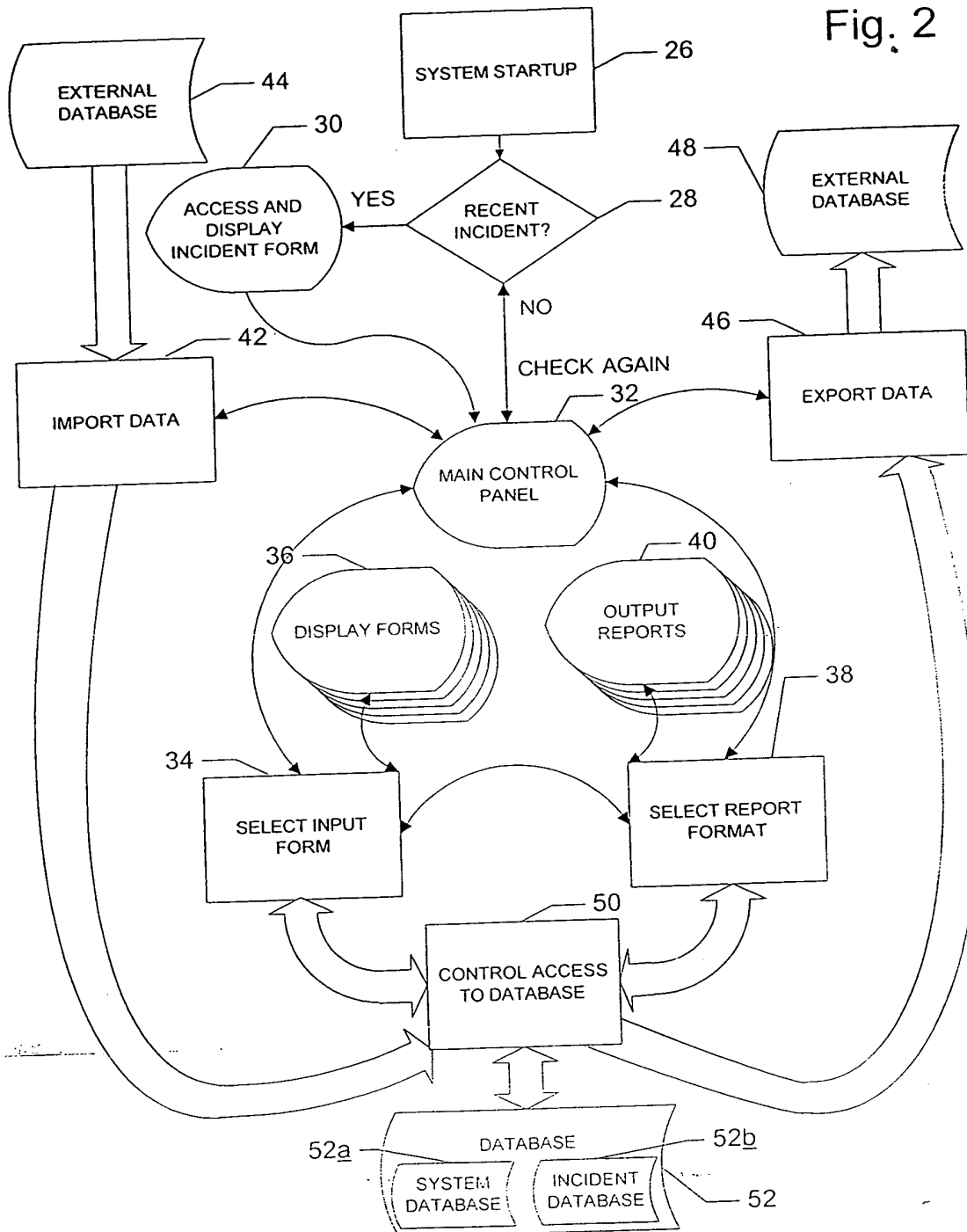


FIG. 3

Accident Report Recap:

|         |                                    |           |   |
|---------|------------------------------------|-----------|---|
| WHAT    | Strains/Sprains                    | Ankle(s)  | <input checked="" type="checkbox"/> Left <input type="checkbox"/> Right |
| WHEN    | 1/17/95                            | HOW LONG  | 1/17/95   |
| HOW BAD | 1/17/95                            | Date Left | Date Returned   |
|         | <input type="checkbox"/> Fatality? |           |   |

Company Accident Description:

Employee sprained ankle when struck by falling beam.

OSHA 200 Form Accident Description:

Accident Vitals

Injury Related

Illness Related

54

56

58

60

| RECORDABLE CASES: You are required to record information about every occupational death, every nonfatal occupational illness, and those nonfatal occupational injuries which involve one or more of the following: loss of consciousness, restriction of work or motion, transfer to another job, or medical treatment (other than first aid). (See definitions on the other side of form.) | Description of Injury or Illness |
|---|----------------------------------|
|---|----------------------------------|

**RECORDABLE CASES:** You are required to record information on occupational death, every nonfatal occupational illness, and those nonfatal occupational injuries which involve one or more of the following: loss of consciousness, restriction of work or motion, transfer to another job, or medical treatment (other than first aid). (See definitions on the other side of form.)

| Case or File Number   | Date of Injury or Onset of Illness | Employee's Name   | Occupation   | Department  | Description of Injury or Illness   |
|---|------------------------------------|---|--|---|--|
| Enter a nonduplicating number which will facilitate comparisons with supplementary records. | Enter Mo./day.                     | Enter first name or initial, middle initial, last name. | Enter regular job title, not activity employee was performing when injured or at onset of illness. In the absence of a formal title, enter a brief description of the employee's duties. | Enter department in which the employee is regularly employed or a description of normal workplace to which employee is assigned, even though temporarily working in another department at the time of the injury or illness | Enter a brief description of the injury or illness and indicate the part or parts of body affected.<br><br>Typical entries for this column might be: Amputation of 1 <sup>st</sup> joint right forefinger; Strain of lower back; Contact dermatitis on both hands; Electrocutation—body. |
| (A)   | (B)                                | (C)   | (D)  | (E)   | (F)  |
|   |                                    |   |  |   | PREVIOUS PAGE TOTALS   |
|   |                                    |   |  |   |  |
|   |                                    |   |  |   |  |
|   |                                    |   |  |   |  |
|   |                                    |   |  |   |  |
|   |                                    |   |  |   |  |
|   |                                    |   |  |   |  |
|   |                                    |   |  |   |  |
|   |                                    |   |  |   |  |
|   |                                    |   |  |   |  |
|   |                                    |   |  |   |  |
|   |                                    |   |  |   | TOTALS (Instructions on other side of form)  |

Company Name \_\_\_\_\_ Page \_\_\_\_\_ of \_\_\_\_\_ For Calendar Year 19 \_\_\_\_\_

Form Approved  
O.M.B. No. 1220-0029

[illegible]

# FIG. 5

Start Year:

End Year:

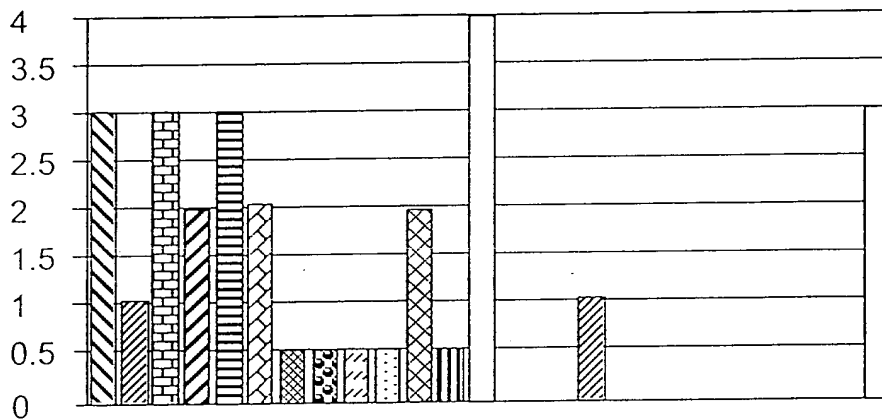
Co:

Locale:

Dept:

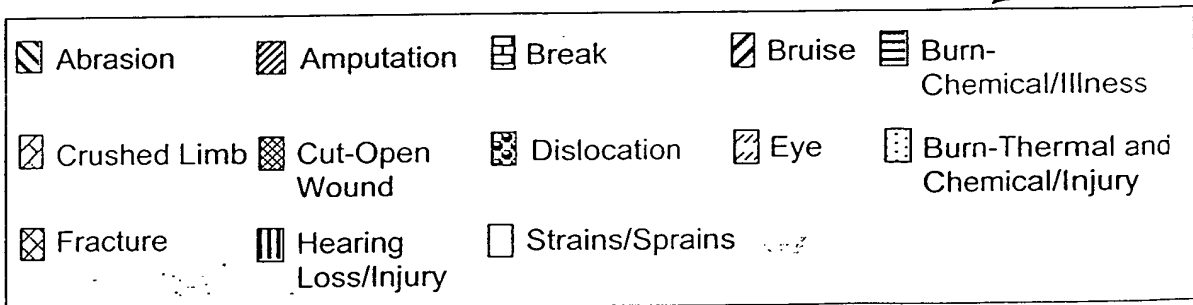
70

## Accident Analysis – By Nature of Injury



66

68



00107026500

FIG. 6

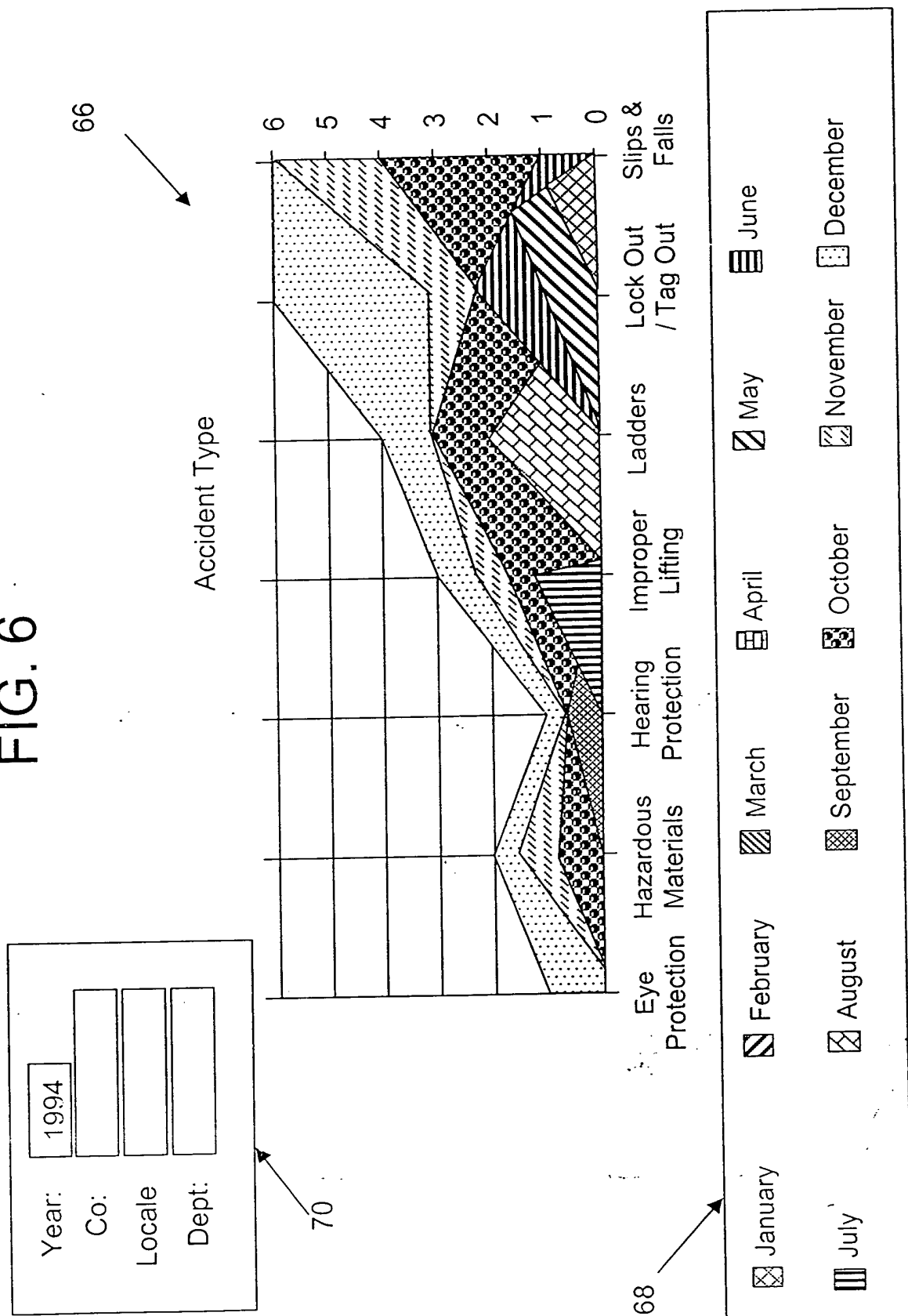
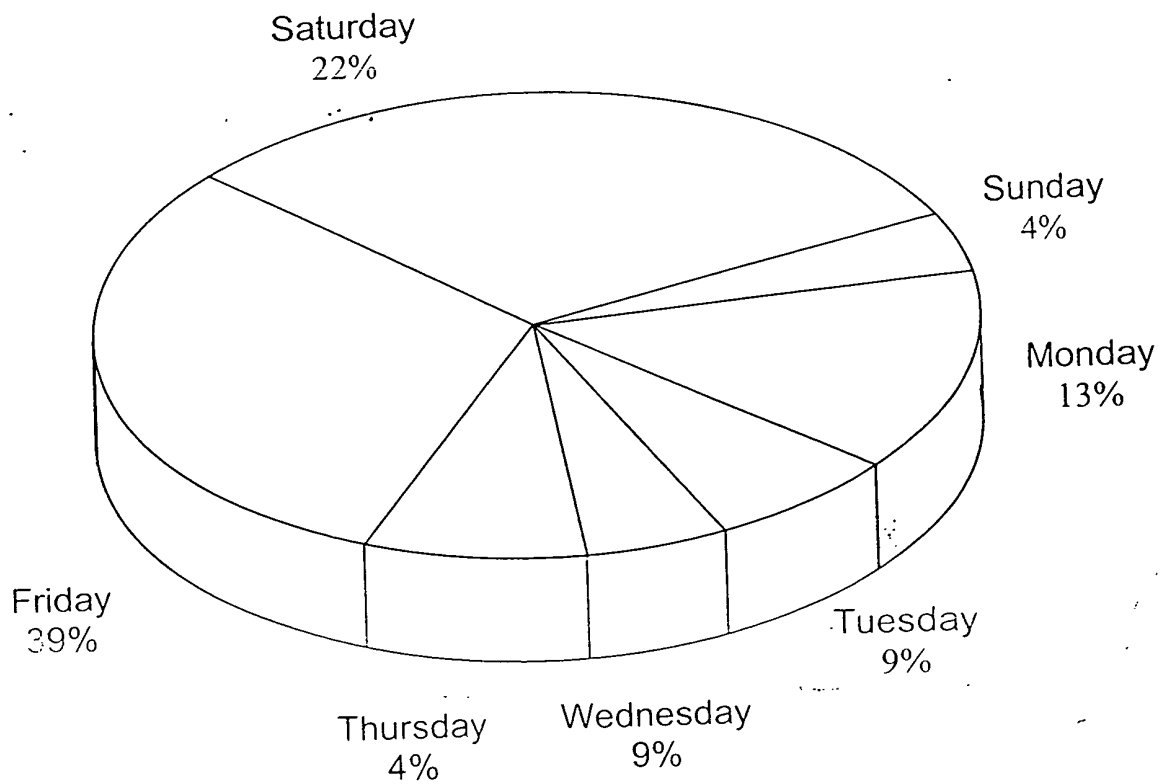


FIG. 7

|        |                                   |
|--------|-----------------------------------|
| Year:  | <input type="text" value="1994"/> |
| Co:    | <input type="text"/>              |
| Locale | <input type="text"/>              |
| Dept:  | <input type="text"/>              |

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Accident Analysis – By Day of the Week





யுத்தம்

## SOS Report – Status Report

Report Date

| REPORT ID / INFO: | INITIAL REPORT | INVESTIGATION |
|-------------------|----------------|---------------|
| 1089              | NATURE         | CAUSE         |
| 1901              | DATE           | P. ACTION     |
| 10875             | C. ACTION      | ACKNOWLED     |
| 1005              | SUPVR.         | COMPLTD       |
| 1698              | ACTION ND      |               |

72

74

Fig. 9

SAFESTAR – Master List All

Participants (Alpha)

REPORT DATE: 11-JUL-95

|                                |                          |
|--------------------------------|--------------------------|
| <u>Vital Statistics:</u>       |                          |
| NAME:                          | BOYNTON, SUSAN           |
| ADDRESS:                       | 13201 NE 44TH STREET #14 |
| CITY/ST/ZIP:                   | VANCOUVER, WA 98682      |
| PHONE:                         | 206-896-9726             |
| <u>Employment Information:</u> |                          |
| SOC. SEC. #                    | 540962944                |
| D.O.B.:                        | 8/3/64                   |
| HIRED/LOE:                     | 5/12/76 - 19 YRS 2 MOS   |
| DPT# NAME                      | 3 - TRUCKING             |

|                                |                        |
|--------------------------------|------------------------|
| <u>Vital Statistics:</u>       |                        |
| NAME:                          | CHAISE, CHEVY          |
| ADDRESS:                       | 499 FOX BLVD.          |
| CITY/ST/ZIP:                   | HOLLYWOOD, CA 76004    |
| PHONE:                         | 310-655-7324           |
| <u>Employment Information:</u> |                        |
| SOC. SEC. #                    | 545069823              |
| D.O.B.:                        | 5/17/47                |
| HIRED/LOE:                     | 4/11/78 - 17 YRS 3 MOS |
| DPT# NAME                      | 2 - OFFICE             |

|                                |                       |
|--------------------------------|-----------------------|
| <u>Vital Statistics:</u>       |                       |
| NAME:                          | GRANT, LOU            |
| ADDRESS:                       | 497 WRITERS DR.       |
| CITY/ST/ZIP:                   | PERIODICAL, NE 97640  |
| PHONE:                         | 402-555-2222          |
| <u>Employment Information:</u> |                       |
| SOC. SEC. #                    | 789879742             |
| D.O.B.:                        | 12/2/40               |
| HIRED/LOE:                     | 6/14/90 - 5 YRS 1 MOS |
| DPT# NAME                      | 5 - RETAIL            |

|                                |                       |
|--------------------------------|-----------------------|
| <u>Vital Statistics:</u>       |                       |
| NAME:                          | JEFFERSON, GEORGE     |
| ADDRESS:                       | 805 HIGH RISE BLVD    |
| CITY/ST/ZIP:                   | NEW YORK, NY 80754    |
| PHONE:                         | 201-555-6890          |
| <u>Employment Information:</u> |                       |
| SOC. SEC. #                    | 773901320             |
| D.O.B.:                        | 8/13/58               |
| HIRED/LOE:                     | 7/18/88 - 7 YRS 0 MOS |
| DPT# NAME                      | 1 - MANUFACTURING     |

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# Accident Report Synopsis – By Period

REPORT DATE: 11-JUL-95

Report Start 01-Jan-94 Report End 01-Jan-95

Fig. 10

Month January

Department 1 - Manufacturing

| INJURY DATE | LAST NAME | FIRST  | SSN       | NATURE OF INJURY   | ACCIDENT TYPE | LOE          | TIME IN DEPT |
|-------------|-----------|--------|-----------|--------------------|---------------|--------------|--------------|
| 1/14/94     | KEATON    | BUSTER | 813902231 | THERMAL & CHEMICAL | LOCK OUT / TA | 1 YRS-10 MOS |              |

|                         |  |
|-------------------------|--|
| ACCIDENT DESCRIPTION    | WHEN A DOOR TO THEM MAIN FURNACE WAS OPENED ACCIDENTALLY, EMPLOYEE'S RIGHT ARM WAS BURNED WHEN THE FURNACE LOCK-OUT / TAG-OUT SWITCH FAILED TO ENGAGE. |
| CORRECTIVE ACTION TAKEN | HAVE SHUT DOWN THE FURNACE AND ORDERED REPAIRS MADE. ALSO, HAVE ADVISED EMPLOYEE OF CORRECT PROCEDURE.   |

Month February

Department 1 - Manufacturing

| INJURY DATE | LAST NAME | FIRST  | SSN       | NATURE OF INJURY | ACCIDENT TYPE | LOE         | TIME IN DEPT |
|-------------|-----------|--------|-----------|------------------|---------------|-------------|--------------|
| 2/11/94     | JEFFERSON | GEORGE | 773901320 | RN-CHEMICAL/ILLN | HAZARDOUS M   | 6 YRS-4 MOS |              |

|                         |                                |
|-------------------------|--------------------------------|
| ACCIDENT DESCRIPTION    | EMPLOYEE BURNED ARM WITH ACID. |
| CORRECTIVE ACTION TAKEN |                                |

| INJURY DATE | LAST NAME | FIRST  | SSN       | NATURE OF INJURY    | ACCIDENT TYPE | LOE       | TIME IN DEPT |
|-------------|-----------|--------|-----------|---------------------|---------------|-----------|--------------|
| 2/11/94     | KEATON    | BUSTER | 813902231 | HEARING LOSS/INJURY | HEARING PROT. | 2 YRS- MO |              |

|                         |  |
|-------------------------|--|
| ACCIDENT DESCRIPTION    | EMPLOYEE RECEIVED HEARING INJURY DUE TO FAILURE TO WEAR HEARING PROTECTION PROPERLY. |
| CORRECTIVE ACTION TAKEN | HAVE ADVISED CORRECT PROCEDURE.  |



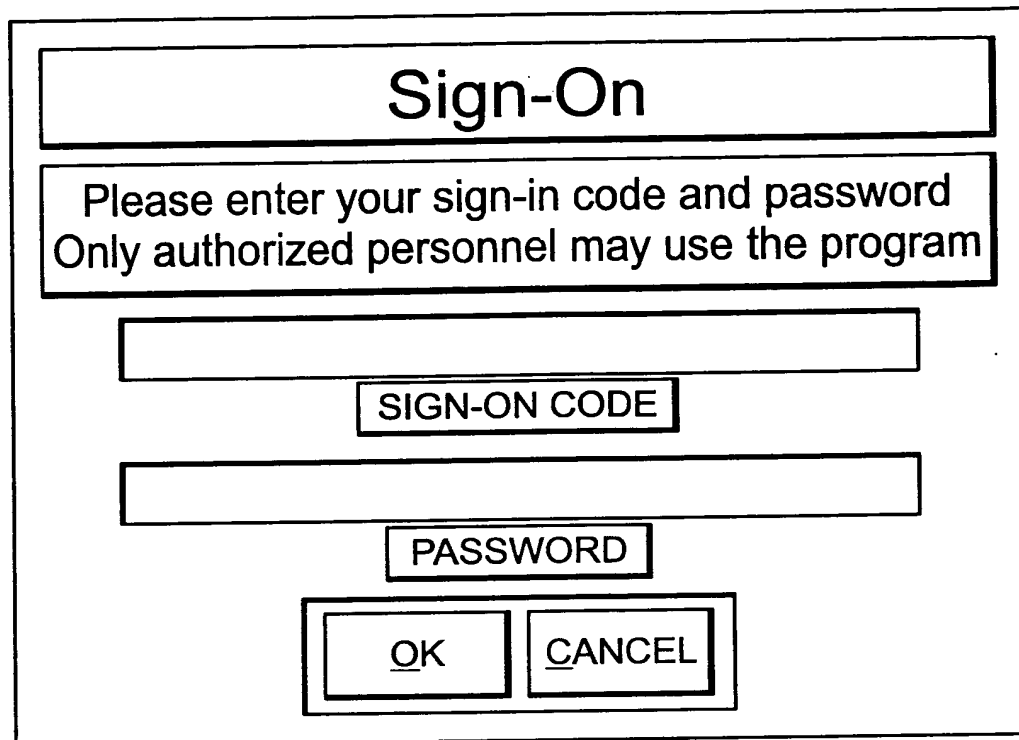


00000000000000000000

Fig. 14

|                                |  |  |  |  |  |
|--------------------------------|--|--|--|--|--|
| <div>MAIN SWITCHBOARD</div>    |  | <div>PERFORMANCE UPDATE</div>                |  | <div>ADD &amp; MODIFY PER-MISSIONS</div> |  |
|                                |  | <div>TODAY'S DATE 3/3/95 TIME 06:58 AM</div> |  |  |  |
|                                |  | <div># ENROLED 13 # ACCIDENTS 32</div>       |  |  |  |
|                                |  | <div>ADMIN "\$" SAVED TO DATE \$800.00</div> |  |  |  |
| <div>FORMS SWITCHBOARD</div>   |  | <div>REPORTS SWITCHBOARD</div>               |  | <div>ON-LINE HELP</div>                  |  |
| <div>CHECK FOR ACCIDENTS</div> |  | <div>DELETE SAMPLE DATA</div>                |  |  |  |
| <div>UTILITY FUNCTIONS</div>   |  | <div>EXPORT FILES</div>                      |  | <div>EXIT SAFESTAR</div>                 |  |
| <div>IMPORT FILES</div>        |  | <div>VERIFY TABLE ATTACHMENTS</div>          |  |  |  |

Fig. 16



A rectangular dialog box titled "Sign-On". Below the title bar, there is a text area containing the instructions: "Please enter your sign-in code and password" and "Only authorized personnel may use the program". Below this text are two horizontal input fields. The first field is labeled "SIGN-ON CODE" and the second is labeled "PASSWORD". At the bottom of the dialog box are two buttons: "OK" and "CANCEL".

**Sign-On**

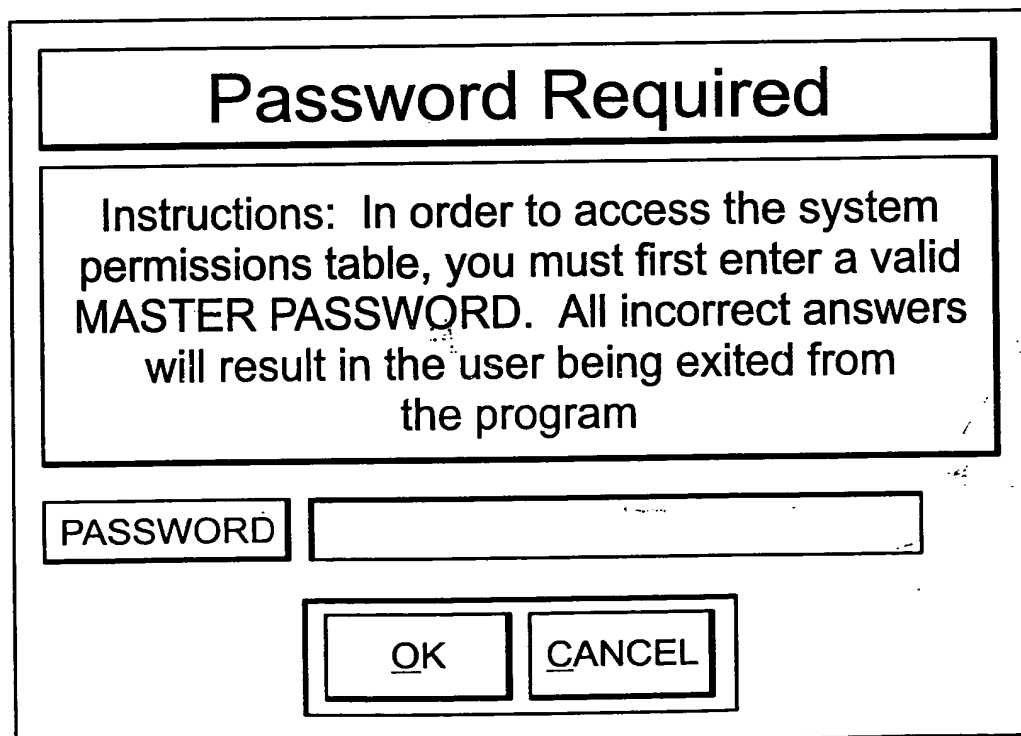
Please enter your sign-in code and password  
Only authorized personnel may use the program

SIGN-ON CODE

PASSWORD

OK CANCEL

Fig. 17



A rectangular dialog box titled "Password Required". Below the title bar, there is a text area containing the instructions: "Instructions: In order to access the system permissions table, you must first enter a valid MASTER PASSWORD. All incorrect answers will result in the user being exited from the program". Below this text is a horizontal input field labeled "PASSWORD". At the bottom of the dialog box are two buttons: "OK" and "CANCEL".

**Password Required**

Instructions: In order to access the system permissions table, you must first enter a valid MASTER PASSWORD. All incorrect answers will result in the user being exited from the program

PASSWORD

OK CANCEL

Fig. 18

| Sign-On Permissions  |  |  |  |   |
|--|--|--|--|---|
| <div style="display: flex; justify-content: space-between; align-items: center;"> <div> <b>LOOKUP:</b> <input style="width: 150px;" type="text"/> </div> <div style="display: flex; gap: 10px;"> <input type="button" value="↶"/> <input type="button" value="↷"/> <input type="button" value="↶↷"/> <input type="button" value="↷↶"/> <input type="button" value="EDIT"/> <input type="button" value="DELETE"/> <input type="button" value="ADD"/> <input type="button" value="CLOSE"/> </div> </div>   |  |  |  |   |
| <p><b>Instructions:</b> To Add/Modify/Delete a permissions record, follow these steps</p> <p><b>Step #1:</b> Sign-On ID= Any letter / number combination that identifies the user (required)</p> <p><b>Step #2:</b> Password = Any letter / number combination (no spaces) that acts as a secondary security level (e.g. dept. name, file name, etc.)</p> <p><b>Step #3:</b> Company = Select a specific company name from the list or leave the "*" if unlimited access is desired, (note: the "*" is the default value, if you want to restrict the records for this user to a specific company you will need to replace the "*" with a company name</p> <p><b>Step #4:</b> Level = Within a given company, Select a specific plant/location # from the list, or leave "*" if unlimited access is desired. (Same note applies as for the company. see Step #3)</p> |  |  |  |   |
| <div style="border: 1px solid black; padding: 5px; display: inline-block;">Master Password</div>   |  |  |  | <div style="border: 1px solid black; padding: 5px; display: inline-block;">Change Master Password</div> |
| <input type="button" value="✎"/>   | <input style="width: 95%;" type="text"/> | <input style="width: 95%;" type="text"/> | <input style="width: 95%;" type="text"/> | <input style="width: 95%;" type="text"/>  |
| *  | <input style="width: 95%;" type="text"/> | <input style="width: 95%;" type="text"/> | <input style="width: 95%;" type="text"/> | <input style="width: 95%;" type="text"/>  |



Fig. 19

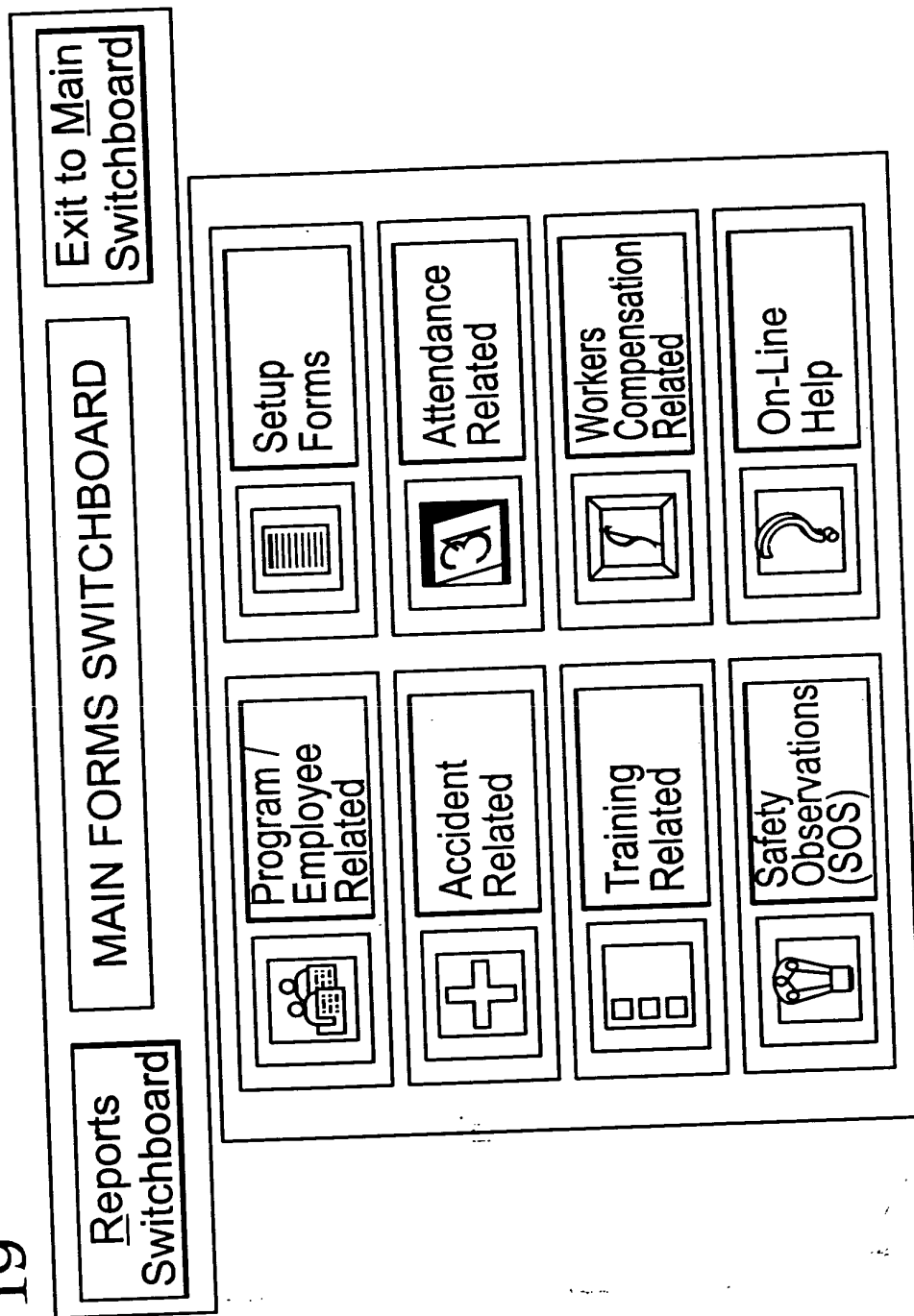


Fig. 20

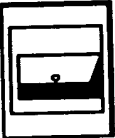
Employee & Program Information

Select Form to Open

☐ Company Setup Form  
☐ Employee Enrollment Form  
☐ Monthly Hours Worked Entry  
☐ Team Change - Quick Entry  
☐ Dept. Change - Quick Entry  
☐ Corporate Holiday Entry

Description

Press to Open Form



Reports Switchboard

Forms Switchboard

Main Switchboard

Fig. 21

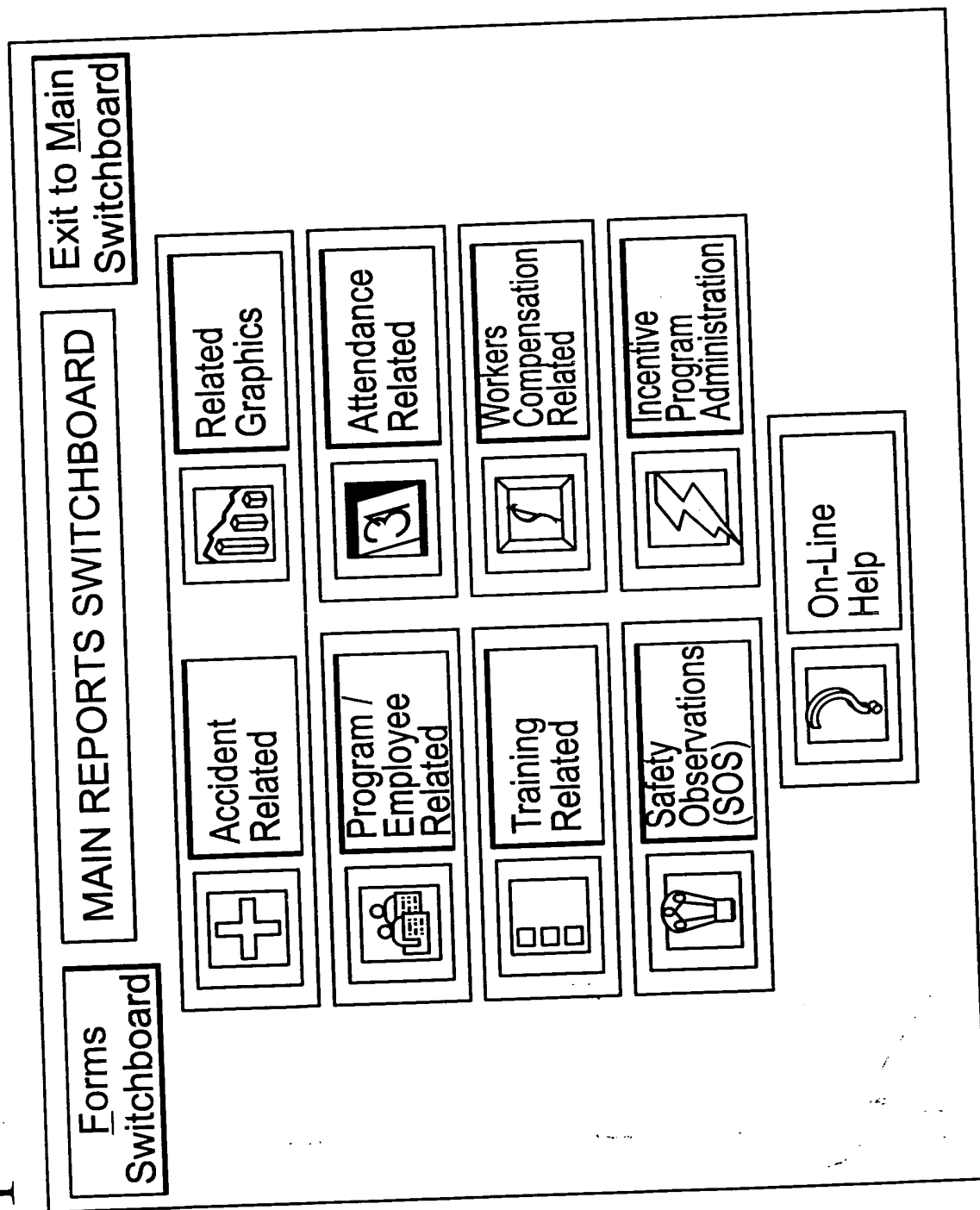


Fig. 22

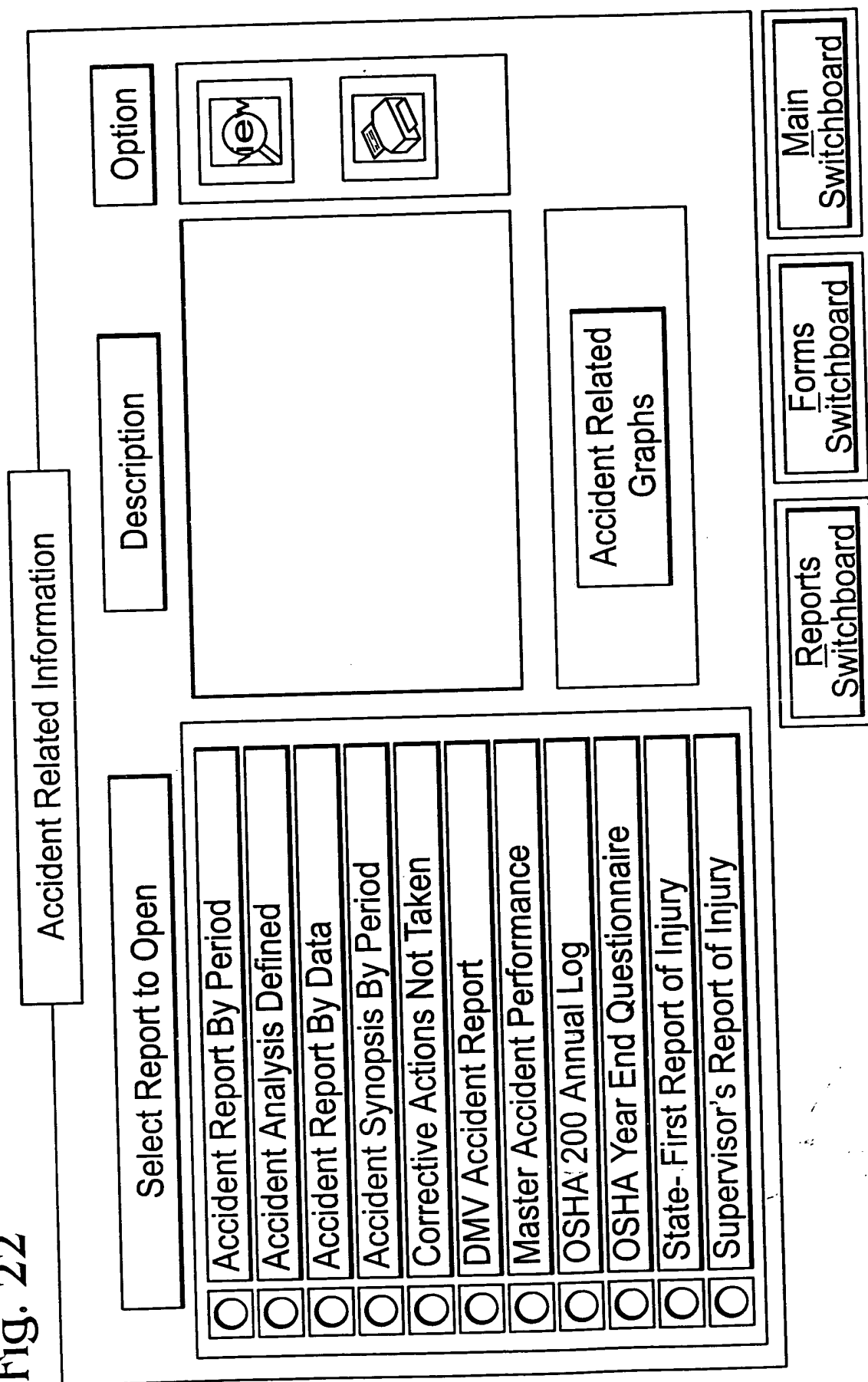


Fig. 23

| Company Setup  |  |              |  |              |   |                       |  |                       |  |
|--|--|--------------|--|--------------|---|-----------------------|--|-----------------------|--|
| Save   |  | Close        |  | Add          |   | Open Dept. Setup Form |  | Configure Printer Now |  |
|  |  | Company Name |  |              |   |                       |  |                       |  |
|  |  | Address      |  |              |   |                       |  | FED ID #              |  |
|  |  | Address      |  |              |   |                       |  |                       |  |
| City   |  | ST           |  | ZIP          |   | County                |  | Telephone             |  |
|  |  |              |  |              |   |                       |  |                       |  |
| Locator #  |  | 999          |  | State of Op: |   |                       |  | Gen. Mgr. or Pres.    |  |
| General Nature of Business:  |  |              |  |              |   |                       |  |                       |  |
| Industry:  |  |              |  | SIC Code:    |   |                       |  |                       |  |
| Primary Hospital:  |  |              |  | Of Record    |   |                       |  |                       |  |
| <div> <div>Page Down</div> <div>Workers Comp. Insurance Info.</div> </div> |  |              |  |              | <div> <div>Page Bottom</div> <div>State Workers Comp. Division Info.</div> </div> |                       |  |                       |  |

[illegible][illegible]

Fig. 28

|            |           |
|------------|-----------|
|            | Counter   |
| LAST       | Text      |
| FIRST      | Text      |
| SSN        | Number    |
| Birthday   | Date/Time |
| LOE        | Text      |
| ADJ        | Date/Time |
| Address    | Text      |
| City       | Text      |
| State      | Text      |
| Zip        | Number    |
| PHONE      | Text      |
| DEPT       | Text      |
| Dept Name  | Text      |
| Company    | Text      |
| Locale     | Text      |
| HrlyRate   | Number    |
| Occupation | Text      |
|            | Text      |

Fig. 25

# Master Enrollment Form

LOOKUP:

ID:

*Required Only for  
Network Installations*

Company Name:   Location:

Last:  First:  Social Security #:  Date of Birth:

Address:

City:  State:  Zip:  Phone Number:

4/11/78

Date of Hire:

6yrs. 11mos.

Length of

Employment:

\$10.00

Hourly Rate

SUPERVISOR

Occupation:

OFFICE

Dept. Name:

*Complete if Safety Awareness  
Program will be used and based  
on "Team" Performance.*

5  FALCONS

Team Code: Team Name:

Fig. 26

## ATTENTION! VERY IMPORTANT INFORMATION

You have selected the IMPORT function of the program.

In the event that you continue without completing all of the required steps and are exited out of the program, be assured that your data will not be lost. However, you will need to restart the program.

Note: You should invoke this function only if you have all of the information required and are ready to import the selected ASCII or Excel Spreadsheet file into the program.

In order for this process to be preformed successfully, the file you are preparing to import MUST BE in the EXACT column and date-type order as the Table you are importing into. If this is not done, unrepairable errors may occur and your imported data will not be complete, or may be imported into the incorrect fields of the Table [eg. Social Security # imported into the LAST name column.]

If you are unsure or need additional information, select the requested Table name and press the PRINT TEMPLATE button, before continuing

Table Template Selection

PRINT  
TEMPLATE

CANCEL

CONTINUE



Fig. 27

### Important Setup Parameters

Select the Source Type of the Data Being Imported

☐ ☐

Text Delimited [ASCII]

Excel Spreadsheet

Lotus WKS file

Lotus WK1 [Version2]

Lotus WK3 [Versions 3 & 4]

Enter Full Path Name of Data to be Imported

Enter Name of Table to Import Data Into

Does the First Row Contain Field Names

☐ YES
 ☐ NO

Replace All of the Existing Records?

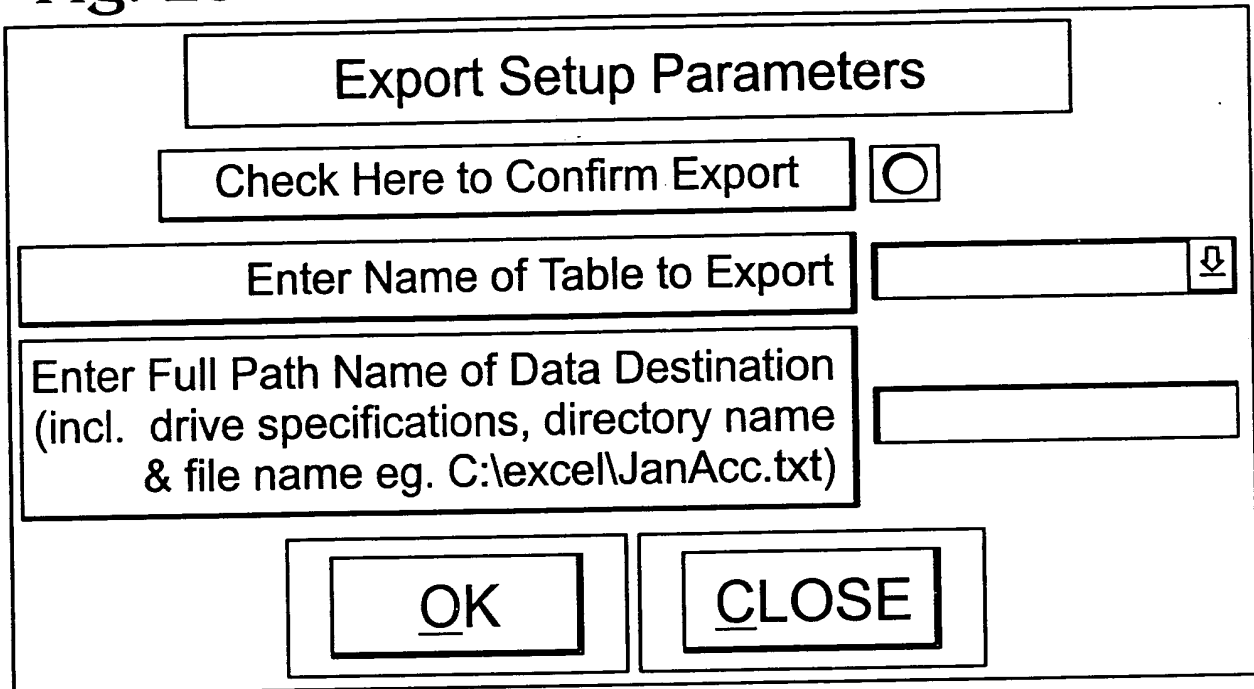
☐ YES
 ☐ NO

Press CLOSE when the import function is completed. (The hour glass will disappear and the floppy drive light will go off.)

OK

CLOSE

Fig. 29



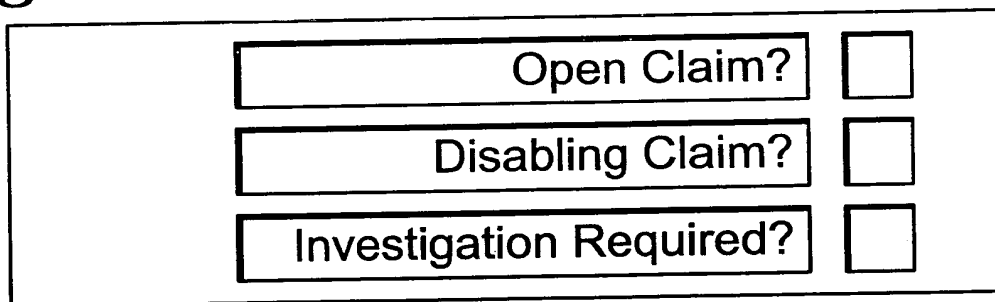
Export Setup Parameters

Check Here to Confirm Export ☐

Enter Name of Table to Export

Enter Full Path Name of Data Destination  
(incl. drive specifications, directory name  
& file name eg. C:\excel\JanAcc.txt)

Fig. 32

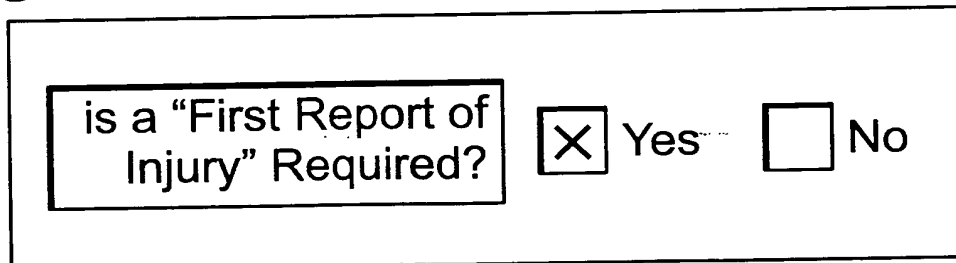


Open Claim? ☐

Disabling Claim? ☐

Investigation Required? ☐

Fig. 33



is a "First Report of Injury" Required? ☒ Yes ☐ No

Fig. 30

| Accident Form  |  | Accident #: 82                      |                                     |
|----------------|--|-------------------------------------|-------------------------------------|
| RECORD LOOKUP: |  | <input type="button" value="F1"/>   | <input type="button" value="F2"/>   |
|                |  | <input type="button" value="F3"/>   | <input type="button" value="F4"/>   |
|                |  | <input type="button" value="F5"/>   | <input type="button" value="F6"/>   |
|                |  | <input type="button" value="F7"/>   | <input type="button" value="F8"/>   |
|                |  | <input type="button" value="F9"/>   | <input type="button" value="F10"/>  |
|                |  | <input type="button" value="F11"/>  | <input type="button" value="F12"/>  |
|                |  | <input type="button" value="F13"/>  | <input type="button" value="F14"/>  |
|                |  | <input type="button" value="F15"/>  | <input type="button" value="F16"/>  |
|                |  | <input type="button" value="F17"/>  | <input type="button" value="F18"/>  |
|                |  | <input type="button" value="F19"/>  | <input type="button" value="F20"/>  |
|                |  | <input type="button" value="F21"/>  | <input type="button" value="F22"/>  |
|                |  | <input type="button" value="F23"/>  | <input type="button" value="F24"/>  |
|                |  | <input type="button" value="F25"/>  | <input type="button" value="F26"/>  |
|                |  | <input type="button" value="F27"/>  | <input type="button" value="F28"/>  |
|                |  | <input type="button" value="F29"/>  | <input type="button" value="F30"/>  |
|                |  | <input type="button" value="F31"/>  | <input type="button" value="F32"/>  |
|                |  | <input type="button" value="F33"/>  | <input type="button" value="F34"/>  |
|                |  | <input type="button" value="F35"/>  | <input type="button" value="F36"/>  |
|                |  | <input type="button" value="F37"/>  | <input type="button" value="F38"/>  |
|                |  | <input type="button" value="F39"/>  | <input type="button" value="F40"/>  |
|                |  | <input type="button" value="F41"/>  | <input type="button" value="F42"/>  |
|                |  | <input type="button" value="F43"/>  | <input type="button" value="F44"/>  |
|                |  | <input type="button" value="F45"/>  | <input type="button" value="F46"/>  |
|                |  | <input type="button" value="F47"/>  | <input type="button" value="F48"/>  |
|                |  | <input type="button" value="F49"/>  | <input type="button" value="F50"/>  |
|                |  | <input type="button" value="F51"/>  | <input type="button" value="F52"/>  |
|                |  | <input type="button" value="F53"/>  | <input type="button" value="F54"/>  |
|                |  | <input type="button" value="F55"/>  | <input type="button" value="F56"/>  |
|                |  | <input type="button" value="F57"/>  | <input type="button" value="F58"/>  |
|                |  | <input type="button" value="F59"/>  | <input type="button" value="F60"/>  |
|                |  | <input type="button" value="F61"/>  | <input type="button" value="F62"/>  |
|                |  | <input type="button" value="F63"/>  | <input type="button" value="F64"/>  |
|                |  | <input type="button" value="F65"/>  | <input type="button" value="F66"/>  |
|                |  | <input type="button" value="F67"/>  | <input type="button" value="F68"/>  |
|                |  | <input type="button" value="F69"/>  | <input type="button" value="F70"/>  |
|                |  | <input type="button" value="F71"/>  | <input type="button" value="F72"/>  |
|                |  | <input type="button" value="F73"/>  | <input type="button" value="F74"/>  |
|                |  | <input type="button" value="F75"/>  | <input type="button" value="F76"/>  |
|                |  | <input type="button" value="F77"/>  | <input type="button" value="F78"/>  |
|                |  | <input type="button" value="F79"/>  | <input type="button" value="F80"/>  |
|                |  | <input type="button" value="F81"/>  | <input type="button" value="F82"/>  |
|                |  | <input type="button" value="F83"/>  | <input type="button" value="F84"/>  |
|                |  | <input type="button" value="F85"/>  | <input type="button" value="F86"/>  |
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Fig. 31

|  |   |   |  |
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| <b>Accident Specifics</b>  |   | Date of Injury: <input type="text" value="2/11/95"/>  | Time of Injury: <input type="text"/>   |
| Hospitalized: <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO            | Hospital: <input type="text"/>  | Physician: <input type="text"/>   |  |
| Body Part Afflicted: <input checked="" type="checkbox"/> RIGHT <input type="checkbox"/> LEFT | Body Part Previously Injured? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |   |  |
| <input type="text" value="WRIST(S)"/>  | If Yes, Explain: <input type="text"/>   |   |  |
| Nature of Injury: <input type="text" value="FRACTURE"/>                                      | Incident Type: <input type="text"/>   |   |  |
| Contrib. Cause: <input type="text" value="HORSEPLAY"/>                                       | Conditions: <input type="text" value="POOR LIGHTING"/>  |   |  |
|  | Awareness Code: <input type="text" value="SLIPS &amp; FALLS"/>                                    |   |  |
| Company Accident Description   |   |   |  |
| <input type="text"/>   |   |   |  |
| Corrective Action Taken  |   | Is a "First Report of Injury" Required? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |  |
| <input type="text"/>   |   | Date Completed: <input type="text"/>  |  |
| <input type="checkbox"/> Open Claim?   | <input type="checkbox"/> Disabling Claim?   | <input type="text" value="Page Up"/>  | <input type="text" value="Page Down"/> |
| <input checked="" type="checkbox"/> Investigation Required?                                  |   | FROI & OSHA Info.   |  |

Fig. 34

| Accident Report - Advanced Information   |   |   |  |
|--|---|---|--|
| <div style="border: 1px solid black; padding: 2px; display: inline-block;">Reference:</div> <div style="border: 1px solid black; width: 150px; height: 20px; margin-top: 2px;"></div>  | <div style="border: 1px solid black; padding: 2px; display: inline-block; float: right;">Return</div>   |   |  |
| <div style="border: 1px solid black; padding: 2px; text-align: center;">Primary Cause.</div> <div style="border: 1px solid black; padding: 2px; text-align: center;">HORSEPLAY</div> <div style="border: 1px solid black; padding: 2px; margin-top: 5px;">Secondary Causes</div> <div style="border: 1px solid black; padding: 2px; margin-top: 2px;">Caught in, Under,</div> <div style="border: 1px solid black; padding: 2px; margin-top: 2px;">Between</div> <div style="border: 1px solid black; padding: 2px; margin-top: 2px;"></div> <div style="border: 1px solid black; padding: 2px; margin-top: 5px;">Summary:</div> <div style="border: 1px solid black; padding: 2px; margin-top: 2px;">Confined Space</div> <div style="border: 1px solid black; padding: 2px; margin-top: 2px;">Excessive Exposure</div> | <div style="border: 1px solid black; padding: 2px; text-align: center;">Primary Condition.</div> <div style="border: 1px solid black; padding: 2px; text-align: center;">POOR LIGHTING</div> <div style="border: 1px solid black; padding: 2px; margin-top: 5px;">Secondary Conditions:</div> <div style="border: 1px solid black; padding: 2px; margin-top: 2px;"></div> <div style="border: 1px solid black; padding: 2px; margin-top: 2px;">EXCESSIVE EXPOSURE</div> <div style="border: 1px solid black; padding: 2px; margin-top: 2px;"></div> <div style="border: 1px solid black; padding: 2px; margin-top: 5px;">Summary:</div> | <div style="border: 1px solid black; padding: 2px; text-align: center;">Primary Witness.</div> <div style="border: 1px solid black; padding: 2px; margin-top: 5px;">Supplemental Witnesses:</div> <div style="border: 1px solid black; padding: 2px; margin-top: 2px;"></div> <div style="border: 1px solid black; padding: 2px; margin-top: 2px;"></div> <div style="border: 1px solid black; padding: 2px; margin-top: 2px;"></div> <div style="border: 1px solid black; padding: 2px; margin-top: 5px;">Summary:</div> |  |

Fig. 35

|  |   |   |   |
|--|---|---|---|
| Employee Accident Description  |   | If version does not differ from Co. Description, copy & paste from above  |   |
| Witness: <input type="text"/>  |   | Street Address of Accident: <input type="text"/>  |   |
| Date Co. Knew: <input type="text"/>  | County of Injury: <input type="text"/>  |   |   |
| Injured on Premises?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO                                    | Injured While on the Job?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNKNOWN                                       | Other Workers Injured?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   | Did someone else cause accident?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |
| Was accident caused by failure of machinery or product?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |   | Is worker an Owner of Officer?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |   |
| Working Shift<br>Start: <input type="text"/> End: <input type="text"/>   | Date Worker Left: <input type="text"/>  | Date Worker Returned: <input type="text"/>  |   |
| Number Hrs. Per Shift:<br><input type="text"/> 8   | Days per week worked:<br>3 or Less <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> | Scheduled Days Off:<br>S <input checked="" type="checkbox"/> M <input type="checkbox"/> T <input type="checkbox"/> W <input type="checkbox"/> T <input type="checkbox"/> F <input type="checkbox"/> | Wage: <input type="text"/> \$9.00<br><input checked="" type="checkbox"/> Hr. <input type="checkbox"/> Wk. <input type="checkbox"/> Yr.<br><input type="checkbox"/> Day <input type="checkbox"/> Mo. |
| Page Up  | Accident Specifics  | Vital Statistics  | Page Down   |
|  |   | OSHA 200 LOG Entry  |   |

Fig. 36

|   |  |   |
|---|--|---|
| <p><b>First Report of Injury - State Exceptions</b></p> <p>In addition to the information already provided, your state also requires the following:</p> |  | <div>RETURN</div>   |
| OSHA CASE #:  |  | Employee Policy #:  |
| Case #:   |  | Was Salary Continued?: <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO              |
| Employee Class Code:  |  | Paid full wages for day of Injury?: <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| Value of other payments not recorded:   |  | If a fatality, what is the date of death?:  |
| Gross Wages/Salary:   |  |   |
| Employer Type:  |  |   |
| Hospital Address:   |  |   |
| Physician's Address:  |  |   |
| What was worker doing at the time of Injury?:   |  | What equipment /material was the employee using during time of Injury?:                                 |

[illegible]

Fig. 38

**Accident Report Recap:**

WHAT **Fracture** Wrist(s) ☐ LEFT ☒ RIGHT

WHEN **12/17/94** HOW LONG

HOW BAD ☐ FATALITY? Date Left: Date Returned:

Company Accident Description

Enter a Unique Case Number:

Push to enter info in Correct Category

OSHA 200 Form Accident Description

Vital Statistics  FROI & OSHA Info.



Fig. 39

| Injury Related           |  | Injures With Lost Work Days                           |                                      |   | Injures Without Lost Workdays   |
|--------------------------|--|---|--------------------------------------|---|---|
| Fatalities               | Nonfatal Injuries  |   |                                      |   |   |
| Injury Related           | Enter a CHECK if injury involves days away from work, or days of restricted work activity or both. | Enter a CHECK if injury involves days away from work. | Enter number of DAYS away from work. | Enter number of DAYS of restricted work activity. | Enter a CHECK if no entry was made in columns 1 or 2 but the injury is recordable as defined above. |
| Mo/da/yr                 | (2)  | (3)   | (4)                                  | (5)   | (6)   |
| (1)                      |  |   |                                      |   |   |
| <input type="checkbox"/> | <input type="checkbox"/>   | <input type="checkbox"/>                              | <input type="checkbox"/>             | <input type="checkbox"/>                          | <input type="checkbox"/>  |

PAGE TOP

Vital Statistics

PAGE UP

OSHA 200 LOG Info.

Fig. 40

|  |  |  |   |  |
|--|--|--|---|--|
| <p><b>(7) Type of Illness</b> <i>Check only one column for each illness</i></p> <p>Occupational Skin Diseases or Disorders <input type="checkbox"/> (a) Disorders Due to Physical Agents <input type="checkbox"/> (e)<br/> Dust Diseases of the Lungs <input type="checkbox"/> (b) Disorders Associated with Repeated Trauma <input type="checkbox"/> (f)<br/> Respiratory Conditions Due to Toxic Agents <input type="checkbox"/> (c) All Other Occupational Illnesses <input type="checkbox"/> (g)<br/> Poisoning (systemic effects of toxic materials) <input type="checkbox"/> (d)</p> |  |  |   |  |
| Illness Related  |  | Illnesses Without Lost Workdays                                |   |  |
| Fatalities   | Nonfatal Illnesses   | Illness With Lost Work Days                                    |   |  |
| Illness Related<br>Enter DATE of death.<br>Mo/da/yr<br>(8)   | Enter a CHECK if illness involves days away from work, or days of restricted work activity or both.<br>(9) | Enter a CHECK if illness involves days away from work.<br>(10) | Enter number of DAYS of restricted work activity.<br>(11) | Enter number of DAYS of restricted work activity.<br>(12)  |
|  | <input type="checkbox"/>   | <input type="checkbox"/>                                       | <input type="checkbox"/>                                  | Enter a CHECK if no entry was made in columns 1 or 2 but the illness is recordable as defined above.<br>(13) |
| <input type="checkbox"/>   | <input type="checkbox"/>   | <input type="checkbox"/>                                       | <input type="checkbox"/>                                  | <input type="checkbox"/>   |



Fig. 42

| Investigation Support  |   |                          |  | COUNT                                  |                       |                                     |  |  |  |                                |          |  |  |  |                      |  |  |  |  |
|--|---|--------------------------|--|--|-----------------------|-------------------------------------|--|--|--|--------------------------------|----------|--|--|--|----------------------|--|--|--|--|
| WHAT   | Break   | WHEN                     | 10/17/94   | -AT- 8:00:00 a.m. COUNT 2              |                       |                                     |  |  |  |                                |          |  |  |  |                      |  |  |  |  |
| WHERE  |   | CONDITION                | Confined Space   | 12                                     |                       |                                     |  |  |  |                                |          |  |  |  |                      |  |  |  |  |
| WHAT KIND  |   | HOW BAD?                 | FATALITY: <input type="checkbox"/>                     | HOSPITALIZED: <input type="checkbox"/> |                       |                                     |  |  |  |                                |          |  |  |  |                      |  |  |  |  |
| BODY PART  | Arm(s) L <input type="checkbox"/> R <input checked="" type="checkbox"/> | OSHA status              | FROI to be Filed?: <input checked="" type="checkbox"/> |  |                       |                                     |  |  |  |                                |          |  |  |  |                      |  |  |  |  |
| HOW LONG?  |   | -TO-                     | 200 Log Recordable? <input type="checkbox"/>           |  |                       |                                     |  |  |  |                                |          |  |  |  |                      |  |  |  |  |
| <table border="1"> <tr> <td>Accident Description:</td> <td colspan="4">Employee's right arm was amputated.</td> </tr> <tr> <td>Corrective Action Description:</td> <td colspan="4">Nothing.</td> </tr> <tr> <td>Probable Root Cause:</td> <td colspan="4"> <div> <div></div> <div> <div>↓</div> <div>Hazard</div> </div> </div> </td> </tr> </table> |   |                          |  |  | Accident Description: | Employee's right arm was amputated. |  |  |  | Corrective Action Description: | Nothing. |  |  |  | Probable Root Cause: | <div> <div></div> <div> <div>↓</div> <div>Hazard</div> </div> </div> |  |  |  |
| Accident Description:  | Employee's right arm was amputated.                                     |                          |  |  |                       |                                     |  |  |  |                                |          |  |  |  |                      |  |  |  |  |
| Corrective Action Description:   | Nothing.  |                          |  |  |                       |                                     |  |  |  |                                |          |  |  |  |                      |  |  |  |  |
| Probable Root Cause:   | <div> <div></div> <div> <div>↓</div> <div>Hazard</div> </div> </div>    |                          |  |  |                       |                                     |  |  |  |                                |          |  |  |  |                      |  |  |  |  |
| Corrective Action Taken:   |   | 10/18/94                 |  |  |                       |                                     |  |  |  |                                |          |  |  |  |                      |  |  |  |  |
| Report Overview  |   | Training & Special Info. |  |  |                       |                                     |  |  |  |                                |          |  |  |  |                      |  |  |  |  |

Fig. 43

|                  |             |              |  |                      |  |
|------------------|-------------|--------------|--|----------------------|--|
| Training History |             |              |  | Investigation Notes: |  |
| Class Name       | Class Date: | Re-Training: | Employee determined to be incompetent. |                      |  |
| Basic CPR        | 1/16/95     | 5/16/95      |  |                      |  |
| Basic CPR        | 5/17/94     | 9/14/94      |  |                      |  |
| Basic CPR        | 6/14/94     | 10/12/94     |  |                      |  |

|  |                  |           |               |                         |
|--|------------------|-----------|---------------|-------------------------|
| Accident History   |                  |           |               | Cause                   |
| Date   | Nature of Injury | Body Part | Incident Type | Condition               |
| 12/2/94  | Bruise           | Ankle(s)  | Struck By     | Slippery Floor          |
| Preventative Action Taken: Have changed policies re: accident procedures |                  |           |               | Date Completed: 1/15/09 |
| Corrective Action Assigned to:   |                  |           |               | Investigated By:        |

|   |   |
|---|---|
| Performance Analysis  |   |
| <div style="display: flex; justify-content: space-between;"> <span>#pp</span> <span>2</span> </div>             | <div style="display: flex; justify-content: space-between;"> <span>Co. Avg. Acc total this</span> <span>100.00%</span> </div> |
| <div style="display: flex; justify-content: space-around;"> <span>Person</span> <span>Performance</span> </div> |   |

Report Overview

Advanced Investigation



Fig. 45

**TRAFFIC ACCIDENT AND INSURANCE REPORT** Accident #

Lookup:  ⬇ ⬅ ➡ ➦ SAVE DELETE ADD CLOSE

**REPORT DIRECTORY**

Employee Lookup:

Employee Name and SS#  ⬇

**Press to Select**

**VEHICLE #1**

|            |                 |
|------------|-----------------|
| Driver     | Vehicle Info    |
| Passengers | Insurance Info. |

**VEHICLE #2**

|        |              |
|--------|--------------|
| Driver | Vehicle Info |
|--------|--------------|

*If Accident involved someone outside of a motor vehicle, answer the following questions.*

**INFORMATION OTHER:**

Involved Pedestrian ☐ Name:

Involved Bicyclist ☐ Address:

Fig. 49

**1ST Quarter**

|                                |                                |                                |
|--------------------------------|--------------------------------|--------------------------------|
| January                        | February                       | March                          |
| <input type="text" value="0"/> | <input type="text" value="0"/> | <input type="text" value="0"/> |

OK Cancel

Fig. 46

**CLOSE**

## Lookup:

15

☐ ☐ ☐ ☐

Dept NameDEPT

**HIRE**

DOB

SSN

**FIRST**

LAST

[illegible]



Fig. 47

## Team Status Change - Quick Entry Screen

Lookup:

LAST

FIRST

SSN

DOB

HIRE

CODE

Team Name

|   |           |            |             |          |          |   |        |
|---|-----------|------------|-------------|----------|----------|---|--------|
| ▶ | Last-name | First-name | 123-45-6789 | 01/23/45 | 12/30/89 | 4 | Eagles |
|   | Last-name | First-name | 123-45-6789 | 01/23/45 | 12/30/89 | 4 | Eagles |
|   | Last-name | First-name | 123-45-6789 | 01/23/45 | 12/30/89 | 4 | Eagles |
|   | Last-name | First-name | 123-45-6789 | 01/23/45 | 12/30/89 | 4 | Eagles |
|   | Last-name | First-name | 123-45-6789 | 01/23/45 | 12/30/89 | 4 | Eagles |
|   | Last-name | First-name | 123-45-6789 | 01/23/45 | 12/30/89 | 4 | Eagles |

Fig. 48

# Monthly Safety Admin. - Hours Worked Entry Form

Year Lookup:

Company Name:

Plant Location#:

Submitted To:

THIS REPORT COVERS THE FISCAL YEAR LISTED BELOW:

Authorization / Routing

General Manager:

Production Manager:

Purchasing Manager:

Select Quarter

Fig. 50

| S.O.S. Report Form   |  |   |  |   |  |                                       |  |   |  |  |  |   |  |
|--|--|---|--|---|--|---------------------------------------|--|---|--|--|--|---|--|
| Lookup: <input type="text"/>   |  | <input type="button" value="Left Arrow"/> |  | <input type="button" value="Right Arrow"/>                                      |  | <input type="button" value="Delete"/> |  | <input type="button" value="Add"/>        |  | <input type="button" value="Close"/>     |  | <input type="button" value="Override"/> |  |
| Report Basics:   |  |   |  | Report ID <input type="text"/>  |  |                                       |  | <input type="button" value="Down Arrow"/> |  |  |  |   |  |
| Reported By:   |  |   |  | <input type="checkbox"/> Company Employee <input type="checkbox"/> Non Employee |  |                                       |  |   |  |  |  |   |  |
| If reported by a company employee, use the "name lookup" box below, to select the person's name who is reporting |  |   |  |   |  |                                       |  |   |  |  |  |   |  |
| Name Lookup:   |  |   |  |   |  |                                       |  |   |  |  |  |   |  |
| <input type="text"/>   |  |   |  | <input type="text"/>  |  |                                       |  | <input type="text"/>                      |  |  |  | <input type="text"/>                    |  |
|  |  |   |  | Last  |  |                                       |  | First                                     |  |  |  |   |  |
| <input type="text"/>   |  |   |  | <input type="text"/>  |  |                                       |  | <input type="text"/>                      |  |  |  | <input type="text"/>                    |  |
| Mail Stop / Location   |  |   |  | Address   |  |                                       |  | City                                      |  |  |  | State                                   |  |
| <input type="text"/>   |  |   |  | <input type="text"/>  |  |                                       |  | <input type="text"/>                      |  |  |  | Zip                                     |  |
| <input type="text"/>   |  |   |  | <input type="text"/>  |  |                                       |  | <input type="text"/>                      |  |  |  | Phone                                   |  |
| Company  |  |   |  |   |  |                                       |  |   |  |  |  |   |  |
| Affected Persons (If different than above i.e. contractor, visitor, etc.): <input type="text"/>                  |  |   |  |   |  |                                       |  |   |  | <input type="button" value="Page Down"/> |  |   |  |
|  |  |   |  |   |  |                                       |  |   |  | Incident Specifics                       |  |   |  |

Fig. 51

|  |  |   |   |
|--|--|---|---|
| Incident Specifics   |  | Date Observed: <input style="width: 100px;" type="text"/>   | Time: <input style="width: 100px;" type="text" value="10:00 A.M."/> |
| Incident Location: <input style="width: 150px;" type="text"/>  | Incident Type: <input style="width: 150px;" type="text" value="↓"/>                    |   |   |
| Incident Nature: <input style="width: 100px;" type="text" value="Break"/>  | Conditions: <input style="width: 150px;" type="text" value="Faulty Floor or Surface"/> |   |   |
| Incident Description   |  | Witness: <input style="width: 150px;" type="text"/>   |   |
|  |  |   |   |
| Corrective Action Taken <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <i>If Yes complete the following information</i>                     |  |   |   |
| Date Completed: <input style="width: 100px;" type="text"/>   |  | Description: <input style="width: 150px;" type="text"/>   |   |
| Did you involve your supervisor? <input type="checkbox"/> Yes <input type="checkbox"/> No    Their Name: <input style="width: 100px;" type="text"/>              |  |   |   |
| Is further action needed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No    If Yes, suggestions: <input style="width: 150px;" type="text"/> |  |   |   |
|  |  | <input style="width: 100px;" type="text" value="Page Up"/> <input style="width: 100px;" type="text" value="Report Basics"/> |   |

Fig. 52

## S.O.S. Investigation

Lookup:

Report Overview

Report ID

Submitted By: 

☐ Company Employee
 ☐ Non Employee

Name

Mail Stop / Location

Address

City

State

Zip

Affected Persons:

Description:

Report Status

Initial Report

Investigation

| Nature               | Date                 | C.Action             | Supvr.               | Action Nd.           | Cause                | P.Action             | Acknowl.             | Completed            |
|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|
| <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |

Incident Investigation

Action & Response



00000000000000000000

Fig. 54

| RE-TRAINING - Enrollment Form |  |            |  |                              |  |                       |  |                               |  |
|-------------------------------|--|------------|--|------------------------------|--|-----------------------|--|-------------------------------|--|
| Class Lookup:                 |  |            |  |                              |  |                       |  | CLOSE                         |  |
| CODE:                         |  | CASS NAME: |  | SUBJECT:                     |  | Re-Training Interval: |  |                               |  |
| CPR 101                       |  | Basic CPR  |  | Basic CPR Technique Training |  | Four Months           |  |                               |  |
| Date:                         |  | 4/1/94     |  | Instructor:                  |  |                       |  | Create New Date:              |  |
| Location:                     |  |            |  | Test ID:                     |  |                       |  | >>Next Date:<br><<Prev. Date: |  |
| Attendees:                    |  |            |  |                              |  |                       |  |                               |  |
| Name Lookup                   |  | Last       |  | Last                         |  | Dept. Name            |  | Company                       |  |
| ▶                             |  | ↓          |  |                              |  |                       |  |                               |  |
|                               |  |            |  |                              |  |                       |  |                               |  |
| ◀◀Record: 1 ▶▶◀▶              |  |            |  |                              |  |                       |  |                               |  |





Fig. 56

| <div style="display: flex; justify-content: space-between; align-items: center;"> <div> <p style="margin: 0;">Session ID</p> <div style="border: 1px solid black; padding: 2px 10px;">CPR 101</div> </div> <div> <p style="margin: 0;">Test</p> <div style="border: 1px solid black; padding: 2px 10px;">Advanced CPR</div> </div> <div> <p style="margin: 0;">Go to Test Entry Screen</p> </div> </div>  |                 |             |                                   |                                 |          |                   |   |   |    |                                  |                                |   |   |   |                                   |              |   |   |    |                                  |             |   |   |    |                                  |                                 |   |   |  |  |  |
|---|-----------------|-------------|-----------------------------------|---------------------------------|----------|-------------------|---|---|----|----------------------------------|--------------------------------|---|---|---|-----------------------------------|--------------|---|---|----|----------------------------------|-------------|---|---|----|----------------------------------|---------------------------------|---|---|--|--|--|
| <div style="display: flex; justify-content: space-between; align-items: center;"> <div> <p style="margin: 0;">Student</p> <div style="border: 1px solid black; padding: 2px 10px;"></div> </div> <div> <p style="margin: 0;">Close</p> </div> </div>  |                 |             |                                   |                                 |          |                   |   |   |    |                                  |                                |   |   |   |                                   |              |   |   |    |                                  |             |   |   |    |                                  |                                 |   |   |  |  |  |
| <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 10%;">Number</th> <th style="width: 10%;">Answer</th> <th style="width: 10%;">Score</th> <th style="width: 40%;">Question</th> <th style="width: 30%;">Correct Responses</th> </tr> </thead> <tbody> <tr> <td>1</td> <td>2</td> <td>10</td> <td>When performing CPR, what is the</td> <td>(2 10) B, 2 breaths to 5 Beats</td> </tr> <tr> <td>2</td> <td>1</td> <td>0</td> <td>Before performing CPR, you should</td> <td>(2 10) FALSE</td> </tr> <tr> <td>3</td> <td>1</td> <td>10</td> <td>You should open a victim's mouth</td> <td>(1 10) TRUE</td> </tr> <tr> <td>4</td> <td>1</td> <td>10</td> <td>How long should you continue the</td> <td>(1 10) A - Until professional m</td> </tr> <tr> <td>0</td> <td>1</td> <td></td> <td></td> <td></td> </tr> </tbody> </table> |                 | Number      | Answer                            | Score                           | Question | Correct Responses | 1 | 2 | 10 | When performing CPR, what is the | (2 10) B, 2 breaths to 5 Beats | 2 | 1 | 0 | Before performing CPR, you should | (2 10) FALSE | 3 | 1 | 10 | You should open a victim's mouth | (1 10) TRUE | 4 | 1 | 10 | How long should you continue the | (1 10) A - Until professional m | 0 | 1 |  |  |  |
| Number  | Answer          | Score       | Question                          | Correct Responses               |          |                   |   |   |    |                                  |                                |   |   |   |                                   |              |   |   |    |                                  |             |   |   |    |                                  |                                 |   |   |  |  |  |
| 1   | 2               | 10          | When performing CPR, what is the  | (2 10) B, 2 breaths to 5 Beats  |          |                   |   |   |    |                                  |                                |   |   |   |                                   |              |   |   |    |                                  |             |   |   |    |                                  |                                 |   |   |  |  |  |
| 2   | 1               | 0           | Before performing CPR, you should | (2 10) FALSE                    |          |                   |   |   |    |                                  |                                |   |   |   |                                   |              |   |   |    |                                  |             |   |   |    |                                  |                                 |   |   |  |  |  |
| 3   | 1               | 10          | You should open a victim's mouth  | (1 10) TRUE                     |          |                   |   |   |    |                                  |                                |   |   |   |                                   |              |   |   |    |                                  |             |   |   |    |                                  |                                 |   |   |  |  |  |
| 4   | 1               | 10          | How long should you continue the  | (1 10) A - Until professional m |          |                   |   |   |    |                                  |                                |   |   |   |                                   |              |   |   |    |                                  |             |   |   |    |                                  |                                 |   |   |  |  |  |
| 0   | 1               |             |                                   |                                 |          |                   |   |   |    |                                  |                                |   |   |   |                                   |              |   |   |    |                                  |             |   |   |    |                                  |                                 |   |   |  |  |  |
| <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%; padding: 5px;">4 Questions</td> <td style="width: 50%; padding: 5px;">30 Points Total</td> </tr> </table>  |                 | 4 Questions | 30 Points Total                   |                                 |          |                   |   |   |    |                                  |                                |   |   |   |                                   |              |   |   |    |                                  |             |   |   |    |                                  |                                 |   |   |  |  |  |
| 4 Questions   | 30 Points Total |             |                                   |                                 |          |                   |   |   |    |                                  |                                |   |   |   |                                   |              |   |   |    |                                  |             |   |   |    |                                  |                                 |   |   |  |  |  |

Fig. 57

Test Question Summary

Test

Advanced CPR

Advanced CPR Training

Modify This Test

Close

| # | Question   | Answer                        | Points |
|---|--|-------------------------------|--------|
| 1 | When performing CPR, what is the correct ratio of for "b | B. 2 breaths to 5 Beats       | 10     |
| 2 | Before performing CPR, you should move the person        | FALSE                         | 10     |
| 3 | You should open a victim's mouth and check for obstruct  | TRUE                          | 10     |
| 4 | How long should you continue the procedure once it i     | A. Until professional medical | 10     |



00000000000000000000

Fig. 59

| Worker's Compensation Analysis - Setup Form  |             |
|--|-------------|
| <input type="button" value="CLOSE"/>   |             |
| Name of Primary Product  | Plastics    |
| Avg. Retail Cost per Unit  | \$15,000.00 |
| Avg. % of Profit per Unit  | 20.00%      |
| # Mfg. Days Req. per Unit  | 1           |
| <input type="button" value="First"/> <input type="button" value="Previous"/> <input type="button" value="Next"/> <input type="button" value="Last"/> |             |
| Record: 1  |             |

Fig. 60

## Advanced Tracking - Entry Screen

LOOKUP:

Soc. Sec. Number:

Name Lookup:

Last

First

Adj. Hire Date:

L.O.E.:

Dept. #:

Dept. Name:

Date Absent:

Date Returned:

Absence Code:

Corrective Action ☒

Corrective Action Taken:

Associate placed on notice of suspension of privileges

Fig. 61

## OSHA 200 Information

||| Record Lookup:



CLOSE

DELETE

### Vital Information

Enter a Case Number:

Name:

Date of Birth

5/17/47

Soc. Sec. #:

Date of Injury:

12/2/94

6/18/81  
Date of Hire:

13yrs - 6mos

L.O.E.:

Department:

5

Dept. Name:

Retail

Time in Dept:

Occupation:

Supervisor

Accident Recap

Injury Related

Illness Related

Fig. 62

Accident Report Recap:

WHAT   ☐ LEFT ☒ RIGHT

WHEN  HOW LONG

HOW BAD ☐ FATALITY? Date Left: Date Returned:

Company Accident Description

Enter a Unique Case Number:

Push to enter info in Correct Category

OSHA 200 Form Accident Description

Vital Statistics  FROI & OSHA Info.

Fig. 66

OSHA - First Report of Injury

Select Accident File

CONFIRMATION

Last Name  Date of Injury

OPTIONS

Fig. 63

| Injury Related       |  | Nonfatal Injuries                                     |                                      |   | Injuries With Lost Work Days  |  | Injuries Without Lost Workdays |
|----------------------|--|---|--------------------------------------|---|---|--|--------------------------------|
| Fatalities           |  |   |                                      |   |   |  |                                |
| Injury Related       | Enter a CHECK if injury involves days away from work, or days of restricted work activity or both. | Enter a CHECK if injury involves days away from work. | Enter number of DAYS away from work. | Enter number of DAYS of restricted work activity. | Enter a CHECK if no entry was made in columns 1 or 2 but the injury is recordable as defined above. |  |                                |
| Enter DATE of death. |  |   |                                      |   |   |  |                                |
| Mo/da/yr             |  |   |                                      |   |   |  |                                |
| (1)                  | (2)  | (3)   | (4)                                  | (5)   | (6)   |  |                                |
| <input type="text"/> | <input type="checkbox"/>   | <input type="checkbox"/>                              | <input type="text" value="0"/>       | <input type="text"/>                              | <input type="checkbox"/>  |  |                                |





Fig. 65

# Accident Analysis - Parameter Defined

## Related Categories

Select report data criteria from any or all of the below listed categories

Nature of Injury

Accident Type

Cause

Condition

Body Part

## Report Period

Enter the report START and END dates

START

END

To further customize your report, one or all of the following may be selected

Company

Division / Plant

Department

Print Preview

Print

OPTIONS

CANCEL

[illegible]

Enter Year To Be Processed

To further customize your OSHA 200 Log one or all of the following may be selected:

Company

Division / Plant

Department

Print Preview

Print

CANCEL

Fig. 68

The image shows a screenshot of a software window titled "OSHA Year End Questionnaire". The window has a standard title bar with a minus sign button. Inside the window, the title is centered at the top. Below the title, there are several input fields and labels. A label "Enter Year To Process" is positioned below a two-part input field. Below this, there are two input fields for months, each with a dropdown arrow icon, labeled "Enter Starting Month:" and "Enter Ending Month:". Below these are two input fields for days, labeled "Starting Day:" and "Ending Day:". A note below these fields states: "Optional. If left blank, all days will be displayed". At the bottom of the window, there is a section titled "OPTIONS" containing three buttons: "Print Preview", "Print", and "CANCEL".

OSHA Year End Questionnaire

Enter Year To Process

Enter Starting Month: ▾

Enter Ending Month: ▾

Starting Day:

Ending Day:

*Optional. If left blank, all days will be displayed*

OPTIONS

Print Preview

Print

CANCEL



Fig. 70

## Accident Related Graphs

Enter Year to Process  
 -to-

Press to Select  
Multi-Yr  
Comparisons

Description:

Option:

Preview

Print

Design

Select Graph to Open:

☐ Accident Reminders

☐ Body Parts

☐ Condition Type

☐ Costs / Hi to Lo

☐ Departments

☐ Freq. By Day of the Week

☐ Freq. By Time of the Day

☐ Incident Types

☐ Injuries Avg. Cost

☐ Monthly Totals

☐ Nature of Injury

☐ PCT By Dept.

To further customize your graphs, one or all of the following may be selected

|                  |    |
|------------------|----|
| Company          | ↓↑ |
| Division / Plant | ↓↑ |
| Department       | ↓↑ |

Fig. 71

MASTER COST ANALYSIS

Report Period

Enter the report START and END dates

START

END

Related Categories

Select report data criteria from any or all of the below listed categories

Nature of Injury

Accident Type

Cause

Condition

Body Part

To further customize your report, one or all of the following may be selected

Company

Division / Plant

Department

OPTIONS

Print Preview

Print

CANCEL